May 2, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0690-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified neurosurgeon. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old male who sustained a work related injury to his back on ___. The patient reported that while at work he was exposed to chemicals in 5/98, after which he noted chronic headaches and dizzy spells. The patient reported that on ___ he fell into a pothole while on the job. The patient reported that he experienced immediate diffuse spine pain, which was further exacerbated after a work related motor vehicle accident that same day. The patient reported an onset of radiating pain, paresthesias and weakness affecting the upper and lower extremities. The patient was treated conservatively without positive effect per the patient. The patient underwent a myeologram with CT of the lumbar spine following, an C4-5 and C6-7 anterior discectomy and fusion with allograft/graft-on putty/anterior C4-5, C5-6, and C6-7 instrumentation with synthes cervical plate on 7/6/99, lumbar discography on 10/16/02, L4-5 laminotomies with partial facetectomies in May 2000 and an EMG.

Requested Services

L3-4, L4-5, L5-S1 decompression with fusion, cages and instrumentation.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 42 year-old male who sustained a work-related injury to his back on ___. The ___ physician reviewer also noted that the patient has been treated with cervical discectomy and fusion and L4-5 laminotomies with partial facetectomies. The ___ physician reviewer explained that the patient had a positive discography at three levels. However, the ___ physician reviewer also explained that this is indicative of no clear identification of the pain generator. Therefore, the ___ physician consultant concluded that the requested L3-4, L5-S1 decopression with fusion cages and instrumentation is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 2nd day of May 2003.